

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**03293 CERTIFICATE OF DEATH**

Reg. Dist. No. 03296 251

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLINGTON</b>		c. LENGTH OF STAY IN 1b <b>no Records</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>ILA</b>		First <b>B</b>	Middle <b>A</b>			
4. DATE OF DEATH <b>MARCH 13 1957</b>		Month <b>MARCH</b>	Day <b>13</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH <b>unknown</b>		9. AGE (In years last birthday) <b>78</b> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>unknown</b>			
12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>						
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>254-28-4058</b>	17. INFORMANT <b>Queen Anne Welfare Board</b> Address <b>Entwistle and</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arterio Sclerosis</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO <b>Don't Know</b> (c) <b>Don't Know</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Don't Know</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Arthritis</b> <b>Insanity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> 19 p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>Mar 12 1957</b> to <b>Mar 13 1957</b> that I last saw the deceased alive on <b>Mar 16 1957</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mullin qth</b> DATE SIGNED <b>Edgar L. Lane</b>						
ACTUAL SIGNATURE <b>H. H. Hamilton</b>		M.D. <b>—</b>				
PHYSICIAN'S NAME (Type) <b>H. H. HAMILTON</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 16 1957</b>		22c. NAME OF CEMETERY OR GREMATORIUM <b>Millington Cemetery</b>		22d. LOCATION (City, town, or county) <b>Millington</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Willow</b>		ADDRESS <b>Millington Md.</b>		24a. REC'D BY REGISTRAR <b>Edgar L. Lane</b>		24b. REGISTRAR'S SIGNATURE <b>Edgar L. Lane</b>
				DATE <b>MAR 19 1957</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03294

## CERTIFICATE OF DEATH

Reg. Dist. No.

113297  
252

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
Queen Anne's Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Centreville	1 yr	Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
MILDRED		ELLEN	BURRIS
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct-6-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife -			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Queen Anne's Md		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William P. Burris		Margaret A. Haggins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		47-36-1316	
17. INFORMANT		Address	
Mrs. W. L. Halton		Centreville Maryland	
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
151X		Carcinoma of the stomach	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
DUE TO			
(b)		Chronic Valvular disease of	
DUE TO			
(c)		the heart	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 1956, to <u>Mar 5</u> , 1957, that I last saw the deceased alive on <u>Mar 5</u> , 1957, and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
H. F. McThosoe		Centreville, Md 317 57	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
H. F. McThosoe			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Buried		Mar 8-57	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Chesterfield		Centreville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Bartin Bus.		Elvie Armstrong	
ADDRESS		DATE 3-8-57	
Centreville Md			
24b. REGISTRAR'S SIGNATURE			
Elvie Armstrong			

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 11 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**03295 CERTIFICATE OF DEATH**

## TERMINOLOGY

**Reg. Dist. No**

253

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x0 CHESTER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
S. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	JAN. 5 - 1875	82	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
HOUSEWIFE				MARYLAND		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
WM. TIMMS		AMANDA LEGG							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(If yes, give war or dates of service)				CORA MYRTLE COLEMAN - CHESTER					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						March 23, 1957			
Cotton any occlusion									
420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						4 years			
DUE TO hypertensive cardio-vascular disease with (b) atrial fibrillation, atrioventricular block, and DUE TO (c) mitral regurgitation, arteriosclerosis (general)						about 6 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from May 10, 1957, to March 23, 1957, that I last saw the deceased alive on March 23, 1957, and that death occurred at 1130 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE Theodor Sattelmair M.D.						DATE SIGNED 3/25/57			
PHYSICIAN'S NAME (Type)		Theodor SATTELMAIER		Stevensville		Stevensville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
BURIAL		MAR. 26		STEVENSVILLE		STEVENSVILLE		KID	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Edgar L. Lane		Church Hill Ind.		DATE		Elizabeth Hopter			

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

RECEIVED

SEARCHED

INDEXED

FILED

SERIALIZED

FILED

RECEIVED  
BUREAU Y. S.

MAR 28 1957

RECEIVED  
BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03296

## CERTIFICATE OF DEATH

Reg. Dist. No.

03299  
233

1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M.D.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER</b>		c. LENGTH OF STAY IN 1b <b>XO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER</b>	
d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SOPHIA</b>		First <b>LAVINIA</b>	Middle <b>Coleman</b>
4. SEX <b>FEM.</b>		5. COLOR OR RACE <b>WHITE</b>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH <b>3-13-1870</b>		8. DATE OF DEATH <b>MARCH 7 1957</b>	
9. AGE (In years, last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
13. FATHER'S NAME <b>JAMES F. KIRWAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY R. GARDNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Reba Coleman</b>	
17. INFORMANT <b>Reba Coleman</b>		Address <b>Chester Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-acute Pleuritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
DUE TO <b>527.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Elephantiasis 15 years ulcers on both legs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Stevensville</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Mar 7 1957</b> to <b>Mar 7 1957</b> last illness, alive on <b>Mar 7 1957</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Stevensville Md.</b> DATE SIGNED <b>3/8/57</b>	
ACTUAL SIGNATURE <b>Dr. Chas. E. Snyder</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. Chas. E. Snyder</b>		Stevensville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Mar. 10</b>		22b. DATE THEREOF <b>Mar. 10, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Stevensville</b>		22d. LOCATION (City, town, or county) <b>Stevensville Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		24a. ADDRESS <b>Church Hill Rd.</b>	
24b. REC'D BY REGISTRAR <b>Elizabeth Hester</b>		24c. REGISTRAR'S SIGNATURE <b>Elizabeth Hester</b>	

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE  
CERTIFICATE OF DEATH

RECEIVED  
MAY 12 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03300

03297

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY S. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Steversville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Steversville x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Hubbard Cromwell		4. DATE OF DEATH	Month March Day 5 Year 1957
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1978 9. AGE (in years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	10c. BIRTHPLACE (State or foreign country) Md.
11. FATHER'S NAME William Cromwell		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. MOTHER'S MAIDEN NAME Millie Watkins		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Rose Glover
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO <i>Caecal Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic C-V Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept</i> , 1951, to <i>March</i> , 1957, that I last saw the deceased alive on <i>March 1</i> , 1957, and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Stevensboro, Md.</i> DATE SIGNED <i>3/3/57</i>	
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/6/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Stevensboro Cem.</i>	22d. LOCATION (City, town, or county) <i>Stevensboro, Md.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>James D. Dashiell, Easton, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR <i>MAR 6 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Helen Aldridge</i>

## CERTIFICATE OF DEATH

NAME

RECEIVED

MAR 6 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**03298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 03301  
 253

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md.</i> b. COUNTY <i>2. 2. a. a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Watapeake</i>		c. LENGTH OF STAY IN 1b <b>c. LENGTH OF STAY IN 1b</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>00</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clear View Village 02822</i>	
d. STREET ADDRESS <i>Pasedene Md</i>		d. STREET ADDRESS <i>Pasedene Md</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Raymond</i>	Middle <i>Lee</i>	Last <i>Duvall</i>
4. DATE OF DEATH	Month <i>March</i>	Day <i>9</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-9-1898</i>
9. AGE (in years last birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Guard. (Westinghouse)</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Richard Duvall</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Babylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>	
17. INFORMANT <i>Helen Cook</i>		Address <i>Brockfield Rd. Balto.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>420.1</i> (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. Henry Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <i>3/9.57</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>3-12-57</i>		22b. DATE THEREOF <i>3-12-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James McCully</i>		ADDRESS <i>130 E. Fort Ave</i>	
24a. REC'D BY REGISTRAR DATE <i>Mar 10, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth Hopter</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03302

03299

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Q.A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Sudlersville		d. STREET ADDRESS Near Dudley Corner		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Dudley Corner				d. STREET ADDRESS Near Dudley Corner		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROSIE MAE HYNSON		First	Middle	Last	4. DATE OF DEATH Mar. 13 1957	Month	Day	Year
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 7, 1897		9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Centreville, Q.A. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Garrison Kilson				14. MOTHER'S MAIDEN NAME Annie Pearce				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-22-6188		17. INFORMANT Romie E. Hynson, Sudlersville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Qaeta Cardiac Deletation		INTERVAL BETWEEN ONSET AND DEATH		
		(b)		Chronic Myocarditis				
		(c)		Chronic Lymphatic Thrombosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				Lunacy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no						
20c. TIME OF INJURY Month, Day, Year Hour a. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sudlersville		(County) (State)
21. I certify that I attended the deceased from <u>Mar. 13</u> , 1957, to <u>Mar. 13</u> , 1957, that I last saw the deceased alive on <u>Mar. 13</u> , 1957, and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Sudlersville, Md.		DATE SIGNED 3/14/57
ACTUAL SIGNATURE <i>C. H. Metcalfe</i>								
PHYSICIAN'S NAME (Type) C. H. Metcalfe						Sudlersville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16/57		22c. NAME OF CEMETERY OR CREMATORIUM Pondtown Cemetery		22d. LOCATION (City, town, or county) Near Crumpton, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin L. Williams - Chelstow, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE 3-15		24b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGELV ED  
MAR 18 1957

BUREAU V. S.  
MAR 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03303  
254

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY					
Queen Anne's MARYLAND		Md. Q. A.					
b. CITY OR TOWN (If, outside corporate limits, write RURAL and give nearest town) Rural - Wye Mills		c. LENGTH OF STAY IN 1b Lifetime					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x1 Rural - Wye Mills					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First	Middle				
Annie		Ellis	Italy				
4. DATE OF DEATH		Month	Day				
March 5		1957					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
F		C		Not known	60 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bill Ellis		14. MOTHER'S MAIDEN NAME Fannie Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. Italy		Address Wye Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 5 yrs +	
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Arterosclerotic Cardio-Vascular Disease				?	
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Queentown, Md.	(County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 1955, to <u>March</u> , 1957, that I last saw the deceased alive on <u>March 4</u> , 1957, and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Queentown, Md.	
ACTUAL SIGNATURE Irvin G. Hoyt MD						DATE SIGNED 3/6/57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF 3/9/57		22c. NAME OF CEMETERY OR CREMATORIAL Chesapeake Cem.		22d. LOCATION (City, town, or county) Queentown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Adair		ADDRESS Easton, Md.		24a. REGD. BY REGISTRAR DATE MAR 8 1957		24b. REGISTRAR'S SIGNATURE Kleen Aldridge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 8 1957

MAR 8 1957

## REGELIV ED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial and transit permit. File pages 1 and 2 with the registrar prior to removal.

VS. A15ME(5)  
 SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 03301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03304254  
 Reg. Dist. No. 277

1. PLACE OF DEATH a. COUNTY  Queen Anne's MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Talbot						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville	c. LENGTH OF STAY IN 1b 1 hr.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels, Md. 20x22						
3. NAME OF DECEASED (Type or print) First RALPH Middle --- Last JONES	d. STREET ADDRESS -----	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> October 1, 1909	9. AGE (In years last birthday) 47 yrs.	4. DATE OF DEATH Month March Day 22, Year 1957	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clam Buyer	10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) Nearvitt, Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Thomas B. Jones	14. MOTHER'S MAIDEN NAME Charlotta Harrison	Address Mrs. Ralph Jones, St. Michaels, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No	16. SOCIAL SECURITY NO. 213-03-0353	17. INFORMANT Mrs. Ralph Jones, St. Michaels, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) L. Henry Fisher	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3/23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 24, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cem.	22d. LOCATION (City, town, or county) Centreville, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Hambleton Harrison, St. Michaels, Md.	ADDRESS	24a. REC'D BY REGISTRAR Date Mar 24/57	24b. REGISTRAR'S SIGNATURE A. J. Fisher, Jr.				

RECEIVED  
BUREAU V. S.

MAR 23 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03302

## **CERTIFICATE OF DEATH**

03305

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <b>QUEENANNE'S</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>QUEEN ANNE'S</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Centreville</b>		c. LENGTH OF STAY IN lb <b>4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Centreville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Mrs. Virginia Newman</b>		First	Middle	Last	4. DATE OF DEATH <b>March 13</b>	
5. SEX <b>Female Colored</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1894</b>	9. AGE (In years last birthday) <b>62 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>						
13. FATHER'S NAME <b>Edward Howell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Brookins</b>		Address <b>Mrs. Ethel Harris, Centreville, Maryland</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-34-7803</b>		17. INFORMANT INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b>		DUE TO <b>Hempstead, Attorney. Scoliosis</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Deceased &amp; Fall down</b>		(b) DUE TO <b></b>				
(c) <b></b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Feb. 1</b> , 1956 to <b>3-13</b> , 1957, that I last saw the deceased alive on <b>2/10</b> , 1956, and that death occurred at <b>Centreville, Md.</b> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Centreville, Md.</b> DATE SIGNED <b>3/13/57</b>						
ACTUAL SIGNATURE <b>H.F.M. 3/13/57</b>						
PHYSICIAN'S NAME (Type) <b>H.F.M. 3/13/57</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 13-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson Co. W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Burt of Burt Bros. Crematory</b>		ADDRESS <b>1</b>		24a. REC'D BY REGISTRAR DATE <b>3/16/57</b>		24b. REGISTRAR'S SIGNATURE <b>Elie Armstrong</b>

CERTIFICATE OF DEATH

BUREAU V. 2

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03303 CERTIFICATE OF DEATH

03306

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Queen Anne MARYLAND		Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
2 Queenstown	Life	2 Queenstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Route 1 Box 51		1 Rt 1, Box 51	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Daisy		B. Rhyanes	
4. DATE OF DEATH	Month	Day	Year
	3	23	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	Col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/14/1896
9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
60 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Domestic	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Emory Brice		Sarah Dobson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
		Joseph Rhyanes	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		March 23, 1957	
420.1		Coronary Thrombosis	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Hypertensive Cardio-vascular disease about 3 years	
DUE TO (b)		Arteriosclerosis general & cerebral about 3 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1957, to March 23, 1957, that I last saw the deceased alive on March 23, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Stevensville March 25, 1957.	
ACTUAL SIGNATURE Theodor Sattelmayer M.D.		Stevensville March 25, 1957.	
PHYSICIAN'S NAME (Type) Theodor SATTELMAYER		Stevensville Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF 3/26/57	
22c. NAME OF CEMETERY OR CREMATORIAL Family Cemetery		22d. LOCATION (City, town, or county) Queenstown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Aldredge, Easton, Md		24a. REC'D BY REGISTRAR APR 3 1957	
		24b. REGISTRAR'S SIGNATURE Helen Aldredge	

WISCONSIN STATE GOVERNMENT INFORMATION SERVICE

CERTIFICATE OF DEATH

BUREAU V. B.  
RECEIVED

APR 3 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103307  
253

03304

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE			
Queen Anne's MARYLAND		Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester	c. LENGTH OF STAY IN 1b 67 yr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chester			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —	d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna	First	Middle	Lost		
4. DATE OF DEATH	Month	Day	Year		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		
F	C	Jan. 14 1890	9. AGE (In years lost birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MIDWIFE	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jesse Lee	14. MOTHER'S MAIDEN NAME Mary Clayton	Address Chester, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Aaron Richardson	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic - Hypertensive CVDisease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chester	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>March 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>57</u> , and that death occurred at <u>Chest</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Levin D. Hoyt</u> PHYSICIAN'S NAME (Type)	ADDRESS (Street, city or town, state) Chester, Md.			DATE SIGNED 3/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-26-57	22b. DATE THEREOF 3-26-57	22c. NAME OF CEMETERY OR CREMATORIAL Chester, Queen Anne's	22d. LOCATION (City, town, or county) Chester, Queen Anne's	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Levin D. Hoyt	ADDRESS 1307 Mad Ave	24a. REC'D BY REGISTRAR MAR 26 1957	24b. REGISTRAR'S SIGNATURE Ely. Hoyt		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. A.

MAY 23 1957

RECEIVED